Santa Rosa MEDICAL GROUP

Medical History

Date: _____

Family History

Personal Yes	Personal No		Family Yes	Family No
☐	☐	Asthma	☐	☐
☐	☐	Arthritis	☐	☐
☐	☐	COPD	☐	☐
☐	☐	Diabetes	☐	☐
☐	☐	Heartburn	☐	☐
☐	☐	Heart Disease	☐	☐
☐	☐	High Cholesterol	☐	☐
☐	☐	High Blood Pressure	☐	☐
☐	☐	Mental Illness	☐	☐
☐	☐	Stroke	☐	☐
☐	☐	Seizures	☐	☐
☐	☐	Cancer	☐	☐

Please describe any "Yes" answers:

Lifestyle/Habits

Alcohol	☐ Yes	☐ No
Caffeine	☐ Yes	☐ No
Cigarettes	☐ Yes	☐ No
Cigars	☐ Yes	☐ No
Coffee	☐ Yes	☐ No
Exercise	☐ Yes	☐ No
Illicit Drugs	☐ Yes	☐ No

Hospitalizations

Hospitalizations ☐ Yes ☐ No

Year: _____ Reason:

Surgeries ☐ Yes ☐ No

Year: _____ Reason:

Blood Transfusions ☐ Yes ☐ No

Year: _____ Reason:

Allergies

Are you allergic to any medications? ☐ Yes ☐ No

If so please list the drug:

Do you have any non-drug allergies? ☐ Yes ☐ No

If so please list the allergy:

Pharmacy:

Medication List

☐ None

Reviewed By:

Cancer Screenings

Colonoscopy	☐ Yes	☐ No	Year_____
Hemocult	☐ Yes	☐ No	Year_____
Mammography	☐ Yes	☐ No	Year_____
Pap Smear	☐ Yes	☐ No	Year_____
PSA	☐ Yes	☐ No	Year_____

Other:

Immunizations

Childhood	☐ Yes	☐ No	Year____
Influenza	☐ Yes	☐ No	Year____
Pneumovax	☐ Yes	☐ No	Year____
Tetanus	☐ Yes	☐ No	Year____

Other:

Is there any other pertinent health information that you would like to list not otherwise noted above? ☐ Yes ☐ No

If yes, please list:

Do you have any religious limitations concerning your health? ☐ Yes ☐ No

If yes, please list:

Patient Name:_____ Date of Birth:_____ M / F